Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model Choice and Competition Playbook

May 2026

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Introduction

Consistent with the Innovation Center's 2025 Strategy Refresh,[1] the "Achieving Healthcare Efficiency through Accountable Design" (AHEAD) Model is designed to address the unsustainable growth of healthcare costs and suboptimal population health outcomes. It relies on a State-led, multi-payer strategy to increase investments in primary care and prevention, and to improve care coordination. The Model also aims to constrain costs through the use of cost growth targets and alternate payment models (APMs), including Hospital Global Budgets (HGB), advanced primary care, and a geographic-based accountable care model.

On September 2, 2025, CMS announced policy changes to the AHEAD Model that advance the Center's commitment to promote choice and competition. States will be required to implement at least two policies – one promoting choice and another fostering competition – to drive progress towards AHEAD total cost of care (TCOC) Targets and improve the functioning of Medicaid and commercial health insurance markets. States must select one policy that promotes choice and one policy that promotes competition from a CMS-developed menu of options.[2] The State Agreement and the Cooperative Agreement[3] are the mechanisms by which CMS and States participating in AHEAD agree to these requirements, including the implementation requirements for each option. Further these agreements will outline State reporting and monitoring requirements as well as corrective actions CMS may take if a State is not in compliance with these agreements.

In the sections below, CMMI explains the expected State requirements in greater detail, the timeframe for State action on the expected requirements, and how these support the objectives of AHEAD.

Policy Options and Timeline

During the Implementation Period of the Model, **States must implement at least one new policy (or an enhancement to an existing policy) from each of the following two categories: promoting consumer choice and promoting competition.**[4,5] The policy options for each category are as follows:

Promoting Choice Options (State selects one):	**Promoting Competition Options** (State selects one):
1. Medicaid Site Neutrality Implementation	a. Modifying Scope of Practice Restrictions
2. Telehealth Access Expansion	b. Certificate of Need Repeal
3. Prescription Drug Price Transparency	c. Network Adequacy Revisions
4. Prohibitions of Non-Compete Clauses	d. Any-Willing Provider Laws Repeal

[1] Strategic Direction | CMS

[2] States must select options from the CMS-developed menu; States cannot propose their own options.

[3] In the event of any inconsistency between this document and, an AHEAD State Agreement and/or Cooperative Agreement executed by the State and CMS, the State Agreement and/or Cooperative Agreement will take precedence.

[4] These opportunities are based on the 2018 strategy paper authored by the Secretaries of Health and Human Services, Treasury, and Labor. See Azar II, Alex M., Steven T. Mnuchin, and Alexander Acosta, "Reforming America's Healthcare System through Choice and Competition," December 3, 2018. Accessed at https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.

[5] States' selected options may impact one or more health insurance markets—Medicare, Medicaid, and/or commercial.

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Implementation Timeline

Performance Year (PY)	Milestone
Year 1	State must select their policy options by the end of PY 1
Year 2	Progress on implementation and State action in place (which may require legislation, regulation, executive order, or interpretive guidance) by the end of PY 2, to be reported in Annual Progress Reports
Year 3	Complete implementation of selected options by the end of PY 3

The State must adhere to the following CMS requirements:

1) Select policies to pursue before January 1 of PY 2.

2) Report on their selections in Annual Progress Reports, including but not limited to descriptions of the following:

    a) the activities performed during the applicable PY to comply with the requirements of each option chosen;

    b) the obstacles the State is experiencing or expecting to experience regarding the State's selected options; and

    c) any information relevant to the State's ability to comply with requirements.

3) Requirements under each selected option must be implemented prior to the start of PY 4. (before January 1 of PY4).

In the next section, CMS offers more detail on the menu of available options for States to choose from, and the implementation steps required under each option.

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Choice: Options for State Action

PROMOTING CHOICE		
(1)	**Implement Medicaid site-neutrality:** this option seeks to drive savings by aligning payments for outpatient services across healthcare settings in Medicaid and is applicable exclusively to hospitals and HOPDS. States may continue to pay clinic encounter rates or clinic-specific payment methodologies where facility and professional costs are not billed separately.	
	Implementation Pathway: 1. States must establish uniform payment rates within their FFS payment systems for the same services within the same benefit categories, regardless of setting. Payment rates must comply with Medicaid requirements, including 1902(a)(30)(A) of the Social Security Act (SSA) [6] and 2. States must prohibit facility fees from being paid to providers for telehealth visits. The professional fee for the services rendered shall still be paid. *States may need to pass legislation, and/or submit Medicaid State Plan Amendments for CMS approval. States can continue to use geographic adjustments to address access concerns in rural or high-cost areas as long as payment rates are uniform within a locality.	**Desired Outcomes:** a. In Medicaid, States could realize savings by shifting care from higher-cost off-campus Hospital Outpatient Department (HOPD) settings to lower-cost settings paid at a lower rate more closely aligned with physician-owned medical practices,[7] allowing for exemptions similar to those in Medicare.[8] b. States could achieve measurable cumulative savings for the program and Medicaid beneficiaries over the Model, helping the State meet Total Cost of Care (TCOC) targets.
(2)	**Improve access to new and/or additional modes of care delivery via telehealth:** this option aims to expand beneficiary choice by increasing the supply of providers via greater access to telehealth & greater participation in interstate licensure compacts.	
	Implementation Pathway: 1. States must allow for more alternatives to in-person services for Medicaid and commercial health insurance (e.g., audio-only, asynchronous telehealth services, remote patient monitoring, home as the originating site for telehealth visits.) To satisfy this requirement, States must add Medicaid coverage of remote patient monitoring (RPM) for postpartum care.[9] If the State already provides RPM for postpartum care prior to PY1, the State must add RPM coverage for the management of at least one (1) chronic disease; 2. **Prior to start of PY4,** States must expand access to providers delivering longitudinal care—particularly in areas experiencing workforce shortages, such as primary care—by joining and implementing at least one of the following interstate licensure compacts: Psychology Interjurisdictional Compact (PSYPACT), Medical Licensure Compact (IMLC), or Nurses Compact (NLC); and 3. **Prior to start of PY6,** States must join and implement all three of the interstate licensure compacts: PSYPACT, IMLC, and NLC.	**Desired Outcomes:** a. State expansion of telehealth coverage would enhance coordination of care (e.g., higher completion rates of recommended 6-week postpartum visits), increased screening rates for postpartum depression or chronic disease complications,[10] and/or improved condition management (e.g., medication adherence).[11, 12] b. State membership in interstate licensure compacts could enhance provider access and reduce wait times, and ensure better management of chronic conditions such as diabetes and hypertension, or decreased utilization of care in higher-cost settings (e.g., in-person ED visits).[13] Also, by implementing interstate licensure compacts, this will ensure that Medicaid beneficiaries can also access care to out-of-state providers.

[6] States must submit Medicaid State Plan amendments for any change in methods, standards, or rates used for payment (42 CFR 430.12). States shall comply with CMS requirements and polices for submission, including applicable upper payment limits.

[7] CMS estimated that site-neutral payment changes proposed for Medicare in the CY 2020 OPPS rule would save $810 million a year and reduce average beneficiary cost-sharing from $23 to $14 per visit. Accessed at https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center.

[8] CMS, CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC), Nov 1, 2022. Accessed at https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2.

[9] Under this option, a State would be expected to expand coverage of RPM for postpartum care in Medicaid, or for management of chronic diseases if they already cover for postpartum care. States could also add asynchronous modalities to enhance care for these conditions.

[10] A 2024 study found that persons enrolled in a postpartum RPM program had lower 6-week postpartum readmission rates (16 few per 1,000 participants) and increased adherence to 6-week postpartum office visits. See Lemon, Lara S., et al., *Clinical Outcomes Following Remote Hypertension Monitoring Program for Postpartum Individuals with Hypertensive Disorders of Pregnancy, American Journal of Obstetrics and Gynecology*, Volume 230, Issue 1, S33-S34 January 2024. Accessed at: https://doi.org/10.1016/j.ajog.2023.11.061

[11] Ezeamii VC, et al., *Revolutionizing Healthcare: How Telemedicine Is Improving Patient Outcomes and Expanding Access to Care.* Cureus. 2024 Jul 5;16(7):e63881. PMID: 39099901; PMCID: PMC11298029. Accessed at https://doi.org/10.7759/cureus.63881.

[12] Barnett, TE, et al., *The Effectiveness of a Care Coordination Home Telehealth Program for Veterans with Diabetes Mellitus: A 2-year follow-up,* Am J of Manag Care, 2006 Aug;12(8):467-74. Accessed at https://pubmed.ncbi.nlm.nih.gov/16886889/.

[13] Nguyen, AM, and M Schaler-Haynes, *Can Interstate Compacts Enhance the Healthcare Workforce?* Milbank Memorial Fund, April 11, 2023. Accessed at https://www.milbank.org/2023/04/can-interstate-licensure-compacts-enhance-the-health-care-workforce/.

PROMOTING CHOICE		
(3)	**Advance prescription drug price transparency:** this option aims to promote prescription drug price transparency by requiring data on drug costs to be reported by entities across the supply chain.[14]	
	Implementation Pathway: 1. States must require price reporting from drug supply chain entities—such as manufacturers, distributors, wholesalers, pharmacy benefit managers (PBMs), & pharmacies—for drugs they deem to be high cost and for drugs with planned price increases (to be specified in the State Agreement); to pursue this option, States may need to follow a model legislation approach;[15] and 2. States must publish statistics or reports on a state-support website that discloses net revenue and pricing for transactions across the drug supply chain, potentially including pricing for drug manufacturers, distributors and wholesalers, PBMs, payers, pharmacies, providers, and patients.[16]	**Desired Outcomes:** a. Policymakers, purchasers, and payers in AHEAD States would have access to information on drug prices and drug price increases before they occur. b. Policymakers, purchasers, payers, and patients could make cost-conscious decisions and control costs, potentially reducing per-capita costs for enrollees and helping States to meet TCOC targets required by AHEAD.[17]
(4)	**Prohibiting the use of non-compete clauses**: this option aims to enhance patient choice and provider employment mobility by prohibiting use of non-compete clauses for licensed health-related professionals.	
	Implementation Pathway: 1. States must prohibit both existing and future non-compete clauses for all physicians, advanced practice clinicians, and other licensed health-related professionals in the State unless CMS approves an exception to modify this option. States seeking such modifications must request from CMS an exception to modify this option prior to PY2. The request can be related to pre-existing non-compete clauses only. 2. When evaluating an exception for pre-existing non-compete clauses, CMS will consider whether a State's ban: impacts hospitals and physicians important to the model; meaningfully reduces the total-radius geographic restrictions for model providers relative to their current baseline (e.g., non-compete clauses within a 50-mile radius could be reduced to 5 miles); meaningfully reduces the time duration a non-compete is in effect (e.g., if no limit, then limit to 1 year); or can exclude high-wage health-related professionals.	**Desired Outcomes:** a. States would increase the supply of providers for patients to choose from, potentially leading to downward pressures on prices and helping States meet TCOC targets required by AHEAD.

[14] For a summary of prescription drug price transparency actions across States, please see NASHP, Prescription Drug Pricing: State Strategy and Implementation from July 15, 2022. Accessed at https://nashp.org/prescription-drug-pricing-state-strategy-implementation/

[15] For an example, please see model legislation as provided for by NASHP, *Model Legislation and Contracts Prescription Drug Pricing,* December 20, 2022. Accessed at https://nashp.org/model-legislation-and-contracts-prescription-drug-pricing/.

[16] Maine offers an example of such a web site. Beginning in 2020, Maine required the Maine Health Data Organization to produce and post on its publicly accessible website a report with several types of analyses for each point in the distribution process. See Maine Health Data Organization, *Third Annual Prescription Drug Transparency Report,* December 14, 2022. Accessed at https://mhdo.maine.gov/RxDrugPricingTransparency.htm.

[17] Kesselheim, Aaron S. *National Analysis of the Requirements and Implementation of State Prescription Drug Price Transparency Laws,* The Milbank Quarterly, May 30, 2025. Accessed at https://onlinelibrary.wiley.com/doi/10.1111/1468-0009.70023.

Competition: Options for State Action

PROMOTING COMPETITION		
(1)	**Modify Scope of Practice Restrictions:** this option seeks to improve access for patients and reduce overall costs by easing scope of practice restrictions for non-physician practitioners, including physician assistants and nurse practitioners.	
	Implementation Pathway: 1. States must remove scope of practice restrictions to independent practice for physician assistants and nurse practitioners. 2. If States have already removed scope of practice restrictions for physician assistants and nurse practitioners prior to PY1, States must additionally remove scope of practice restrictions for other providers. CMS and the State must consult to determine which provider types qualify as "other providers" to comply with this requirement. (e.g., certified nurse midwives).	**Desired Outcomes:** a. State action could reduce wait times, (particularly in primary care, behavioral health, and rural areas), increase provider supply in Health Professional Shortage Areas, and/or reduce in per-visit costs (due to substitution of lower-cost provider types).[18] b. State action could improve health outcomes for chronic conditions.[19]
(2)	**Change certificate of need requirements:** this option aims to create downward pressure on healthcare prices by simplifying certificate of need requirements for hospitals and by removing these requirements for non-hospital settings.	
	Implementation Pathway: 1. States must **simplify CON processes for hospitals** to alleviate burden on applicants in accordance with the following requirements: i. States must provide administrative relief for all CON processes which may include: fee reduction, simplified reporting requirements, and clear and efficient timelines (e.g., automatically approving a CON if decision deadline is not met). States must also raise thresholds for expenditures that trigger a CON and adjust for inflation. The amounts for fee reduction and the threshold increase, as well as the criteria for state actions to qualify as administrative relief, will be mutually agreed upon by CMS and States prior to PY1; ii. States must develop and implement conflict of interest safeguards for CON regulators, including not limited to disclosing regulatory board's financial ties and excluding competitors from participating in CON decisions (eliminate the "competitor's veto"); and iii. States must ensure transparency of administrative processes, internal review, and outcomes related to CON processes according to standards mutually agreed upon by CMS and States prior to PY1. 2. States must **repeal CON requirements for non-hospital facilities** in accordance with the following requirements: i. If States determine an automatic repeal could reasonably result in disruptions to the market that would negatively affect the goals of the AHEAD model, CMS will accept a 2-year phase-out repeal for non-hospital facilities.[20] ii. The phase-out period must be mutually agreed upon by CMS and States prior to the start of PY2.	**Desired Outcomes:** a. State action on administrative relief for hospitals and the repeal of CON requirements for non-hospital facilities could help address healthcare shortages and create downward pressure on healthcare prices, particularly where new non-hospital entrants can compete with hospitals. b. State action to shift care to lower-cost settings could reduce overall system costs, helping States meet their TCOC targets.

[18] DePriest K, D'Aoust R, Samuel L, Commodore-Mensah Y, Hanson G, Slade EP. Nurse practitioners' workforce outcomes under implementation of full practice authority. Nurse Outlook. 2020 Jul-Aug;68(4):459-467. doi: 10.1016/j.outlook.2020.05.008. Epub 2020 Jun 24. PMID: 32593462; PMCID: PMC7581487. Accessed at https://pubmed.ncbi.nlm.nih.gov/32593462/.

[19] McMenamin A, Turi E, Schlak A, Poghosyan L. A Systematic Review of Outcomes Related to Nurse Practitioner-Delivered Primary Care for Multiple Chronic Conditions. Med Care Res Rev. 2023 Dec;80(6):563-581. doi: 10.1177/10775587231186720. Epub 2023 Jul 12. PMID: 37438917; PMCID: PMC10784406. Accessed at https://pmc.ncbi.nlm.nih.gov/articles/PMC10784406/.

[20] The State may propose an alternative strategy, including data to demonstrate how the State's proposal aligns with CMS' goals for competition.

PROMOTING COMPETITION		
(3)	**Revising network adequacy provisions in compliance with federal requirements:** this option aims to expand access to care by giving States greater ability to set network adequacy standards and requiring States to ensure provider directories are accurate.	
	Implementation Pathway: States must review, revise, and align network adequacy requirements for Medicaid and commercial markets (required for individual and small group markets, optional for large group markets) to meaningfully measure access for enrollees, identifying gaps and opportunities based on input from Medicaid and commercial plans; create flexibilities where appropriate based on the results of the State's reviews, in consultation with CMS; and validate provider directories to ensure network accuracy. 1. States must develop and submit a proposed plan for revising and aligning network adequacy requirements to CMS for approval, by the end of PY1. Any desired changes to network adequacy may require technical assistance from CMCS, and/or CMMI to ensure that any changes (e.g., telehealth flexibilities) remain in compliance with federal rulemaking / regulations. 2. To ensure network accuracy, States must validate provider directories using claims data or other data that measures real-time directory accuracy as agreed upon by CMS and the State.	**Desired Outcomes:** a. State action could improve timeliness and accessibility of care by expanding the availability of providers. b. States action could enhance network interoperability and accuracy by reducing phantom providers listed in provider directories, decreasing out-of-network billing errors, and empowering patients to more easily find care that aligns with their specific needs, preferences, and coverage.[21]
(4)	**Repealing Any-Willing Provider Law:** this option increases the ability of health plans to design provider networks in order to direct patients toward higher-value providers, reduce low-value care, and lower overall costs.	
	Implementation Pathway: 1. States must repeal any willing provider (AWP) laws that require commercial insurers and Medicaid managed care plans to contract with any provider who agrees to the terms and conditions of a contract offered by a commercial insurer or Medicaid managed care plan, regardless of whether the provider meets the quality and geographic access needs of the commercial insurer or Medicaid managed care plan. 2. If States conclude that provider shortages may result because of these requirements, States may implement a 2-year phase-out of applicable AWP laws. CMS and States shall mutually agree on the parameters of any phase-out parameters prior to PY 2.	**Desired Outcomes:** a. State action could enhance provider network composition and performance provider, potentially resulting in improved Healthcare Effectiveness Data and Information Set (HEDIS) quality performance and reduced costs.[22]

[21] Centers for Medicare & Medicaid Services. (2025, May 7). *Qualified Health Plan (QHP) Directory Pilot: Frequently Asked Questions*. Retrieved from https://www.cms.gov/files/document/qhp-directory-pilot-faqs.pdf.

[22] Azar II, Alex M., Steven T. Mnuchin, and Alexander Acosta, "Reforming America's Healthcare System through Choice and Competition," p. 65, December 3, 2018. Accessed at https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.